C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N. R.H.I.T., Chief BUREAU OF FACILITY STANDAROS 3232 Elder Street P.O. Box 83720 Boise, IO 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

May 1, 2012

Julie Taylor, Administrator West Valley Medical Center 1717 Arlington Street Caldwell, ID 83605

RE: West Valley Medical Center, Provider #130014

Dear Ms. Taylor:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on April 19, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Julie Taylor, Administrator May 1, 2012 Page 2 of 2

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by May 14, 2012. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm Enclosures

PRINTED: 04/27/2012 FORM APPROVED OMB NO. 0938-0391

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ABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE	-1	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

May 14, 2012

Aimee Hastriter Sylvia Creswell Bureau of Facility Standards 3232 Elder Street Boise, ID 83720-0036



RE: West Valley Medical Center, Provider #130014

Dear Ms. Hastriter; Ms. Creswell

Per your letter dated May 1, 2012 pursuant to the complaint investigation conducted April 19, 2012, please find enclosed the completed Statement of Deficiencies/Plan of Correction, CMS Form 2567.

If you have any questions, please contact me at (208) 455-3718.

Sincerely,

Julie A. Taylor

Chief Executive Officer

Enc.

FORM APPROVED OMB NO. 0938-0391

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Any deficiency statement ending with an asteristu") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	patient. The Supervisor of C was interviewed on reviewed the hospit rights and acknowle process of how paticaregivers/represer rights information if through a registrar. double check to corproduced additional the hospital failed procedures to effect representatives had exercise rights on the 482.13(c)(1) PATIE PRIVACY The patient has the This STANDARD is Based on review of policies, and intervity hospital failed to end the records were review health information to who had not been a guardian to receive Patient #1 was an atthe hospital on 11/1 bowel obstruction (viewed)	Quality and Risk Management 4/18/12 at 1:15 PM. She al's policies related to patient edged they did not include a ents and/or natives would receive patient this did not occur with contact She stated she wanted to infirm this, but had not information as of 4/19/12.		117	The Quality and Risk Manage Supervisor will assure the provision of mandatory does education on DPOA, legal or patient representative changes, new process, rece of PHI to clinical staff PT, OT, SP, CM, CNA) and Registration.	cumented guardian policy eivers	09/01/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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A 143	SNF and was discontinuous admitted to the homogeneous and phone been written in. At this information receat, "Friend - Do status. [Name of governous admitted by the homogeneous admitted by the homog	cal record indicated she was espital after an evaluation in the record contained insferred with her from the SNF cuments of appointment of an "Admission Face Sheet" the bottom of face sheet, the number of an individual had hand written message next to eferenced the individual and not contact [with] [change] of guardian] is guardian." cal record contained a mission" document. The his document, on 11/16/11at the a second witness, and wrote to sign at all." There was no indicate the legal guardian was not rights and responsibilities, to limit the release of PHI on the contact on PHI on the	A 143	The Quality and Risk Manag Supervisor will revise pol process change with the Di of Patient Care Services t the SW documents and conta DPOA, legal guardian or pa representative as required	icy and rector o assure cts the	09/01/12
	at 3:04 PM that Patient #1's son, family friend,					-

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 143	11:30 AM. Each R authorized to releathe patient. RN E who was unable to guardian, she would guardianship and to determine who was PHI. RN F explain confused and gave with an individual, sufficient regardleshad a legal guardia understood a legal behalf of the patier incapacitated. The "VERIFICATION REQUESTORS" prindicated "Every m must verity the idea when the person or workforce member health information or via written requested when the person or workforce member health information or via written requested mechanisms to verone of which was ra "minimum of three specific list. The "USE AND DISTINGALTH INFORMA MEMBERS OR FREDURPOSES" policity reviewed. According is present for or other conditions and the specific lost.	ere interviewed on 4/19/12 at IN confirmed they were not see PHI without consent from explained that if the patient, give consent, had a legal of require proof of the legal then allow the guardian to a sauthorized to obtain patient ed that if a patient was not estaff permission to share PHI that consent was considered as of whether or not a patient an. She stated that she guardian to make decisions on the when the patient was	A 1	43	The Quality and Risk Manage Supervisor and/or Director or designee will conduct ar via observation or intervie competency and follow through clinical staff (Nurse, PT, CM, CNA) and PAS/Registration the understanding of who receive of PHI.	of HIM n audit ew on the ugh of OT, SP	12/01/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 143	access to PHI may of the following has emergent situations direction to staff regard provide authorithe patient did not healthcare decision representative such	use or disclose the PHI if one cocurred" Except in s, the policy did not include garding who may determine ization for release of PHI when have the capacity to make is and required a n as a legal guardian.	A	143			





C.L., 'BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6826 FAX 208-364-1888

May 1, 2012

Julie Taylor, Administrator West Valley Medical Center 1717 Arlington Street Caldwell, ID 83605

Provider #130014

Dear Ms. Taylor:

On April 19, 2012, a complaint survey was conducted at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005331

Allegation #1: The guardian/patient representative was not notified of a patient's discharge from the facility.

Finding #1: An unannounced complaint investigation was conducted from 4/17/12 through 4/19/12. Facility policies and patient medical records were reviewed. Staff and patients/guardians were interviewed. Grievance documentation was reviewed.

The discharge planning process was reviewed. The facility utilized a combination of Registered Nurse (RN) Case Managers and Social Workers to develop and implement appropriate discharge plans. An RN Case Manager was interviewed. She stated that the Case Managers and Social Workers meet frequently throughout the week to coordinate patient discharge planning efforts.

Ten medical records were reviewed. Nine of the records reviewed contained documentation of appropriate discharge planning, including the involvement of the patients and/or their representatives at the time of discharge.

Julie Taylor, Administrator May 1, 2012 Page 2 of 3

One of these medical records contained documentation of an 82 year old female admitted to the facility for care of an infection in her blood stream and a small bowel obstruction which required surgery to correct. The medical record contained documentation the patient was transferred from the skilled nursing facility, where she resided, to the Emergency Department of the facility. Paperwork transferred with the patient included information regarding her court-appointed guardian.

The medical record record contained documentation of the guardian's involvement in making medical decisions for the patient. However, the medical record did not contain documentation that the guardian was notified when the patient was transferred back to the skilled nursing facility. An unknown individual signed for receipt of the patient discharge instructions.

The guardian for this patient was interviewed. She stated that she was aware the patient would return to the skilled nursing facility but was not aware of when this was to occur. She confirmed that she did not sign the patient discharge instruction form and was not sure who would have signed it.

Five additional patients/guardians were interviewed. Each stated they had no discharge planning concerns and were aware of the discharge plan.

Eight grievances were reviewed. One grievance was related to the above patient and the issue related to the patient's discharge. The grievance documentation indicated an investigation and discussion with the social worker involved in the discharge of the patient back to the skilled nursing facility. The documentation included a phone call between the guardian and the social worker and a grievance letter sent to the guardian. The documentation confirmed the facility acknowledged the guardian was not notified of the patient's discharge to the skilled nursing facility as a result of the social worker's oversight.

The facility failed to ensure a guardian was notified of a patient's discharge. The allegation is substantiated, however no other deficiencies related to discharge planning were identified. Related deficiencies were cited at 42 CFR 482.13(a)(1) Patient Rights: Notice of Patient Rights, for the failure of the facility to ensure guardians received patient rights information and at 42 CFR 482.13 (c)(1) Patient Rights: Personal Privacy, for the failure of the facility to ensure personal information was not released to unauthorized individuals.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Julie Taylor, Administrator May 1, 2012 Page 3 of 3

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm





C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Bosse, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

May 5, 2012

Julie Taylor, Administrator West Valley Medical Center 1717 Arlington Street Caldwell, ID 83605

Provider #130014

Dear Ms. Taylor:

On April 19, 2012, a complaint survey was conducted at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005401

Allegation #1: Patients in the Mental Health Unit were not informed of rights prior to care.

Findings #1: An unannounced visit was made to the hospital on 4/17/12 through 4/19/12. During the complaint investigation, surveyors toured the hospital, interviewed staff and patients, and reviewed policies, grievances, staffing schedules, and 10 patient records.

Patient Rights Information was observed to be posted on hallway walls in the Mental Health Unit. Three current patients were interviewed on the Mental Health Unit on 4/18/12 to determine if they were aware of their rights. All of them said they were aware they had rights and knew information was posted on the Unit.

A hospital admission form, "Conditions of Admission" included the following information:

"I have been furnished with written information regarding patient right and responsibilities and other information related to my stay"

"I have been given the opportunity to read and ask questions about the information contained in

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this form... and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction."

Four patient records were reviewed of patients admitted on a voluntary basis to the Mental Health Unit. All of them had initials and signatures acknowledging receipt of patient rights. For example, a 19 year old female's signature was on the admission document, dated 1/17/12, after an evaluation in the ED on 1/17/12.

It could not be determined the hospital did not inform patients on the Mental Health Unit of patient rights.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients were inappropriately denied rights. They were not given paper and writing utensils to write down questions and information about medications. They were not allowed to wear their own clothing. Their cell phones were taken away. Their books were censured. They were not allowed to have visitors the first day.

Findings #2: A "Patient and Family Handbook," for patients admitted to the Mental Health Unit was reviewed. It included information about what to expect during the first 24 hours, daily activities, unit rules, medications, groups, money and valuables, lost items, luggage, visitors, receiving mail/packages, smoking policy, pastoral service, level system, use of restraints, advanced directives, telephone calls, confidentiality, gifts, emergencies/fire safety, fall risk assessment, food and beverage, and prohibited items. The handbook was included in an admission packet that also included a notebook for patients to write information down.

A Mental Health Unit policy, "Monitoring Self-Harming," stated patients on self-harm precautions will be on Level 1 and in hospital pajamas until staff and the physician have adequately assessed the patient's suicidal/self-harm intent and/or plan.

The Director of the Mental Health Unit was interviewed on 4/18/12 between 9:15 AM and 10:30 AM. She confirmed patients were not allowed to have visitors or their own clothing after admission to the Mental Health Unit until a physician had evaluated them. She confirmed patients were not allowed to have cells phones. When asked how a patient could access telephone numbers from cell phones, she stated they could look up numbers in their cells phones under supervision of a staff member. She stated writing pads were given to patients in an admission packet upon admission to the Mental Health Unit and had been available for years to patients. Writing utensils were available for specific tasks and generally re-collected for safety reasons because they could be used as a weapon for self-harm. She stated the "Patient and Family Handbook" was new within the last couple of months and may not have been available to

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a patient who was admitted in January, 2012.

Three current patients were interviewed on 4/18/12. They expressed understanding of the rules on the Mental Health Unit and denied any concerns or complaints about restrictions.

Although, information regarding rules in the Mental Health Unit may not have been clearly available in January, 2012, it could not be determined the hospital denied patients their rights.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients who were admitted voluntarily were inappropriately held against their will.

Findings #3: The Director of Mental Health was interviewed on 4/18/12 between 9:15 AM and 10:30 AM. When asked if patients who were admitted on a voluntary basis were allowed to leave when they chose, she explained that it depended on the circumstances. She said if a patient came in on a voluntary basis and there was risk of self-harm, the patient would be encouraged to stay on a voluntary basis until the physician could do an evaluation and determine if the patient was safe to leave. If the patient wanted to leave before it was determined he/she was safe to leave, the physician might have to put the patient on an administrative hold, changing her status to involuntary, pending evaluation. She explained the hospital had a responsibility to protect patients from self-harm.

Five patient records on the Mental Health Unit were reviewed, four of whom were initially admitted on a voluntary basis. Documentation indicated staff followed the process described. For example, a 19 year old patient was admitted from the Emergency Department to the Mental Health Unit on a voluntary basis on 1/17/12. Physician orders, dated 1/17/12 at 5:20 PM, included an order for suicide precautions. An Emergency Department nursing note, dated 1/17/12 at 10:07 PM described the patient's chief complaint as "depression and suicidal thoughts." A psychiatrist's evalution, dated 1/18/12 (dictated 8:51 AM), indicated the patient had "persistent thoughts of self-harm." A nursing note, dated 1/18/12 at 5:51 PM, documented the patient requested to leave "earlier on shift." The nurse documented informing the patient of the potential outcomes of leaving and then notifying the doctor of the patient's wish to leave. The patient agreed to stay on a voluntary basis until the following morning when she could discuss the issue with her physician. The next day, 1/19/12 (untimed), the psychiatrist documented evaluating the patient. He determined she was tolerating her medication well and he documented the patient denied suicidal ideation and felt her condition had improved and she was no longer a danger to herself. He wrote an order for her discharge. The patient signed discharge instructions on 1/19/12 at 12:15 PM.

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It could not be determined the hospital inappropriately held patients against their wills.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The Mental Health Unit did not have sufficient staff to meet patient needs.

Findings #4: Surveyors reviewed the staffing grid that showed how many nurses, social workers and psych-techs were expected to work on the Mental Health unit, depending on how many patients were present. Surveyors then compared this information against the patient census and the as-worked staffing schedules for selected periods of time, including 1/17/12 to 1/19/12 and the week prior to survey, 4/08/12 to 4/14/12. All of the shifts, except one, were staffed according to the expected staffing grid. On the dayshift that was missing a nursing staff, they had an "extra" social worker to help with non-RN responsibilities, such as screening patients in the emergency department, for appropriateness of admission to the unit.

The Director of Mental Health was interviewed on 4/18/12. When asked how they handled a busy unit or staff absences, she stated they had multiple ways of handling the situation. She explained, whenever necessary, they called staff to come in on days and times they were not scheduled. If not available, they utilized staff from the float pool to fill a position. She also stated an extra social worker could fill a gap of another staff member being absent.

Three current patients were interviewed on 4/18/12. All of the patients said there were plenty of staff available to attend to their needs. They denied concerns about staffing levels.

The hospital had a process for ensuring adequate numbers of staff were present to meet patient needs. It could not be determined the hospital Mental Health Unit was short-staff.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients were expected to take medications without understanding the medications or agreeing to take them. Patients were threatened to be put on administrative hold if they if they were reluctant to take medications or wanted more information prior to agreeing to take medications.

Findings #5: "Patient Rights," were posted in common areas on the Mental Health Unit. They included the right "to request or refuse treatment."

The Director of Mental Health Services was interviewed on 4/18/12 at 9:15-9:30 AM. She stated patient's could ask for and expect to receive information about their medications. They could write down information about medications on journal paper that was given to them on admission.

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They could request written information about medications. She also stated the hospital provided an education group to help patients to learn about medications.

Three current patients were interviewed on 4/18/12. All patients stated they had opportunities to ask questions about and receive answers related to their medications. One patient stated, "they keep telling me about my medications but I have a bad memory and forget." Another patient stated she went to an education group and learned about her medications. They all denied having any concerns about not understanding their medications. One individual, who was on an administrative hold, said he knew he could refuse to take his medications.

There was lack of sufficient evidence to indicate patients were not educated about their medications or were threatened with administrative hold if they questioned their medications or refused to take them. Therefore, no deficiences were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: A patient's shirt was lost.

Findings #6: An admission consent, "Condition of Admission," included the following information regarding personal valuables. "I understand the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars (\$500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient."

A Mental Health Unit "Patient and Family Handbook" had a section, "Lost Items." It stated the hospital was not responsible for lost items. It encouraged patients to send all valuables home at the time of admission and stated a safe area was available on the unit to secure valuables.

A general hospital policy, "Patient Valuables," dated 10/12/10, stated should patients arrive with valuables, they will first be instructed to return their valuables to their home. When patients are unable to return valuables home, or to safekeeping outside of the medical facility, the hospital will provide for their safekeeping but will not assume responsibility for their protection. With every possible effort taken to prevent valuables from entering/staying within the facility and protecting those that we are advised of, the hospital does not make a policy of reimbursing the patient/family for any items that may be lost/misplaced.

The Director of Mental Health was interviewed on 4/18/12 between 9:15 AM and 10:30 AM.

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When asked about patient belongings that were lost during an admission to the Mental Health Unit, she stated if the item was documented and lost, the patient could send a receipt and the hospital would replace it. She stated that had occurred before on the Unit and when she became aware of it and a receipt was presented, she authorized reimbursement.

One record documented a lost item belonging to a 19 year old who was admitted on 1/17/12. A nurse's note, dated 1/19/12 at 2:24 AM indicated the patient asked for her shirt (that had been inventoried on the property sheet). The note stated the staff member was not able to locate the patient's shirt. There was no indication at discharge that it had been found and returned to the patient. There was no documentation to indicate the patient had submitted a receipt and requested reimbursement.

It could not be determined the hospital violated a patient's rights when a shirt came up missing.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AIMEE HASTRITER

Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm



C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N., R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Bolse, ID 837 20-0009 PHONE 208-334-6626 FAX 208-364-1888

May 1, 2012

Julie Taylor, Administrator West Valley Medical Center 1717 Arlington Street Caldwell, ID 83605

Provider #130014

Dear Ms. Taylor:

On April 19, 2012, a complaint survey was conducted at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005441

Allegation #1: Nursing staff failed to provide interventions as needed.

Finding #1: An unannounced complaint investigation survey was conducted from 4/17/12 through 4/19/12. Medical records and facility policies were reviewed. Staff and patients were interviewed. Care was observed on the Mental Health Unit (MHU).

Three current MHU patients were interviewed individually on 4/18/12. Each patient stated staff were readily available to respond to needs, concerns, and questions. Each patient stated staff treated them with respect and provided them with the treatment and care they felt they needed. Each patient stated staff provided them with food and/or drink when they requested it.

Staff were observed passing medications and performing assessments on 4/19/12 between 8:30 AM and 9:00 AM. Staff were observed to be attentive and respectful toward patients. Staff answered and responded to patients' questions, requests, and concerns.

Six MHU medical records were reviewed. All six records contained documentation of staff responding to patient concerns, educating patients, and caring for the patients' medical and psychological needs.

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One record reviewed documented a 42 year old female admitted to MHU on 2/06/12. In addition to psychiatric diagnoses, the patient required continuous oxygen use. On admission, the patient was on 2 liters per minute of oxygen. On 2/07/12, the physician ordered the patient's oxygen use to be increased to 3 liters per minute. On 2/08/12 at 7:38 AM, an RN documented the patient reporting "my oxygen is out," and in the same note documented, "old bottle replaced with new one."

On 2/08/12, an RN documented the patient was choking on a bagel at breakfast. Staff assessed for the need to intervene and deemed intervention unnecessary. However, a speech therapy evaluation was ordered by the physician immediately following this event. A Speech Therapist performed an evaluation later that day and the patient's diet was changed to prevent choking.

The Director of MHU was interviewed on 4/18/12. She stated patients admitted to MHU with oxygen use requirements were evaluated by a Respiratory Therapist (RT). She stated an RT provided 3-4 portable oxygen tanks per patient per shift and that an RT comes every shift to replace empty tanks with full tanks. She further stated all patients with oxygen needs were also provided with a large oxygen concentrator tank in their room for use at night.

It could not be determined nursing staff failed to provide interventions as needed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff failed to perform safety checks as ordered by the physician.

Finding #2: An unannounced complaint investigation survey was conducted from 4/17/12 through 4/19/12. Medical records and facility policies were reviewed. Staff and patients were interviewed. Care was observed on the Mental Health Unit (MHU).

The Director of the MHU was interviewed on 4/18/12. She stated that all MHU patients were to be observed and documented by staff every 15 minutes, unless the physician ordered more frequent observations.

Six MHU medical records were reviewed for documentation of safety checks being performed. All six records contained documentation of safety checks being performed every 15 minutes from admit to discharge.

On 4/19/12 from 8:30 AM to 9:00 AM, two Psychiatric Technicians were observed performing safety checks every 15 minutes. The patient census on 4/19/12 was 14 patients. All 14 patients' safety check forms were reviewed for accuracy and timeliness of documentation. All 14 safety check forms were current and accurate.

Three current MHU patients were interviewed individually on 4/18/12. They each stated they felt staff were attentive to their needs and that there was enough staff to provide individual care.

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They also stated staff checked on them very frequently, but did not specify how often.

It could not be determined staff failed to perform safety checks as ordered by the physician.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Staff failed to maintain privacy of patient healthcare information.

Finding #3: An unannounced complaint investigation survey was conducted from 4/17/12 through 4/19/12. Medical records and facility policies were reviewed. Staff and patients were interviewed. Care was observed on the Mental Health Unit (MHU).

Three current MHU patients were interviewed individually on 4/18/12. Each stated they felt staff maintained their privacy at all times, including when passing medications. Each stated staff did not talk about patients' personal healthcare information where other patients could overhear.

Staff were observed passing medications and performing assessments on 4/19/12 between 8:30 AM and 9:00 AM. In one instance, a Registered Nurse (RN) brought a patient's medication to her room, where she was resting alone. The RN explained the medications, the patient took the medications, and the RN assessed the patient's mood all while maintaining privacy. In another instance, an RN gave a patient her medications at the door to the nurses' station. The surveyor was within three feet of the RN and the patient, but still had difficulty hearing the discussion between the RN and the patient as their voices were kept low to avoid being overheard by other patients.

It could not be determined staff failed to maintain privacy of patient healthcare information.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

AIMEE HASTRITER Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

AH/srm